FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045484

Facility Name: BRENTWOOD NORTH NSG & REHAB CTR

Address: 3705 DEERFIELD ROAD (Number) RIVERWOODS (City) 60015 (Zip Code)

County: LAKE

Telephone Number: (847) 459-1200 **Fax #** (847) 459-0113

IDPA ID Number: 364445521001

Date of Initial License for Current Owners: 07/21/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/21/01 to 01/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	48,360	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	48,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,094	5,599	8,143	14,836	8
9	SNF/PED					9
10	ICF	3,101	8,539		11,640	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,195	14,138	8,143	26,476	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.75%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/21/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/21/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 248 and days of care provided 5333

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CT # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	225,974	22,456	975	249,405		249,405	469	249,874			1
2	Food Purchase		167,128		167,128	(2,410)	164,718	(3,354)	161,364			2
3	Housekeeping	142,986	17,539		160,525		160,525		160,525			3
4	Laundry	56,449	11,323		67,772		67,772		67,772			4
5	Heat and Other Utilities			90,904	90,904		90,904	850	91,754			5
6	Maintenance	79,818		42,085	121,903		121,903	(5,882)	116,021			6
7	Other (specify):*							208	208			7
8	TOTAL General Services	505,227	218,446	133,964	857,637	(2,410)	855,227	(7,709)	847,518			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,428,187	97,173	483,847	2,009,207		2,009,207	10,511	2,019,718			10
10a	Therapy	10,104	44,692		54,796		54,796	(5,855)	48,941			10a
11	Activities	70,278	13,590		83,868		83,868		83,868			11
12	Social Services	34,986		2,120	37,106		37,106		37,106			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,857	2,857			15
16	TOTAL Health Care and Programs	1,543,555	155,455	497,967	2,196,977		2,196,977	7,513	2,204,490			16
	C. General Administration											
17	Administrative	43,060		355,643	398,703		398,703	(241,009)	157,694			17
18	Directors Fees											18
19	Professional Services			11,488	11,488		11,488	9,568	21,056			19
20	Dues, Fees, Subscriptions & Promotions			137,500	137,500		137,500	(90,074)	47,426			20
21	Clerical & General Office Expenses	111,969	40,003	100,284	252,256		252,256	(6,835)	245,421			21
22	Employee Benefits & Payroll Taxes			327,269	327,269	2,410	329,679		329,679			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,618	3,618		3,618	(943)	2,675			24
25	Other Admin. Staff Transportation			1,655	1,655		1,655		1,655			25
26	Insurance-Prop.Liab.Malpractice			231,071	231,071		231,071	11	231,082			26
27	Other (specify):*							31,425	31,425			27
28	TOTAL General Administration	155,029	40,003	1,168,528	1,363,560	2,410	1,365,970	(297,857)	1,068,114			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,203,811	413,904	1,800,459	4,418,174		4,418,174	(298,053)	4,120,121			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR #0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,613	15,613		15,613	227,127	242,740			30
31	Amortization of Pre-Op. & Org.							52,250	52,250			31
32	Interest			22,825	22,825		22,825	403,375	426,200			32
33	Real Estate Taxes			98,500	98,500		98,500	(1,235)	97,265			33
34	Rent-Facility & Grounds			468,062	468,062		468,062	(456,331)	11,731			34
35	Rent-Equipment & Vehicles			6,888	6,888		6,888	(6,288)	600			35
36	Other (specify):*											36
37	**TOTAL Ownership**			611,888	611,888		611,888	218,898	830,786			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		273,950	551,399	825,349		825,349	(70,898)	754,451			39
40	Barber and Beauty Shops			14,022	14,022		14,022	(14,022)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,168	72,168		72,168	372	72,540			42
43	Other (specify):*	57,669		11,875	69,544		69,544	(69,544)				43
44	**TOTAL Special Cost Centers**	57,669	273,950	649,464	981,083		981,083	(154,092)	826,991			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,261,480	687,854	3,061,811	6,011,145		6,011,145	(233,247)	5,777,898			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,469)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,065)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(129,877)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(885)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,335)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,000)	21		24
25	Fund Raising, Advertising and Promotional	(93,772)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(185,917)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (493,320)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	260,073		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 260,073		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (233,247)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRENTWOOD NORTH NSG & REHAB CTR

ID# 0045484

Report Period Beginning: 07/21/01

Ending: 01/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cable TV	$ (3,383)	21	1
2	Meals & Entertainment	(818)	24	2
3	Marketing Salaries & Expenses	(69,544)	43	3
4	Cred. CD Fees	(3,860)	21	4
5	Bank Charges	(2,165)	21	5
6	Capitalized Repairs & Maintenance	(6,062)	6	6
7	Building Co. - Bank Charges	(44)	21	7
8	Building Co. - Prior Owner Bed Tax	(73,470)	42	8
9	Add one day of Bed Tax	372	42	9
10	Out of Period Seminars	(450)	24	10
11	Real Estate Tax Interest	(1,235)	33	11
12	Wheelchair Revenue	(7,089)	35	12
13	Barber & Beauty Income	(14,022)	40	13
14	Incontinence Revenue	(4,038)	10	14
15	Building Co. - Office Expense	(109)	21	15
16				16
17				17
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				132			14			323		469	1
2	Food Purchase	(3,354)											(3,354)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			617			233						850	5
6	Maintenance	(6,062)		25			155						(5,882)	6
7	Other (specify):*				118			90					208	7
8	**TOTAL General Services**	(9,416)		642	250		388	104			323		(7,709)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,038)		9,607			5,958				(1,016)		10,511	10
10a	Therapy									(5,855)			(5,855)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			1,577			1,280						2,857	15
16	**TOTAL Health Care and Programs**	(4,038)		11,184			7,238			(5,855)	(1,016)		7,513	16
	C. General Administration													
17	Administrative			48,899		(6,971)	52,139	(335,076)					(241,009)	17
18	Directors Fees													18
19	Professional Services			3,111		2,199	4,258						9,568	19
20	Fees, Subscriptions & Promotions	(95,107)		3,058		12	1,963						(90,074)	20
21	Clerical & General Office Expenses	(88,626)	153	43,707			37,931						(6,835)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,268)		88			237						(943)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			10			1						11	26
27	Other (specify):*			12,959		1,335	17,131						31,425	27
28	**TOTAL General Administration**	(185,001)	153	111,832		(3,425)	113,660	(335,076)					(297,857)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(198,455)	153	123,658	250	(3,425)	121,286	(334,972)		(5,855)	(693)		(298,053)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(129,877)	350,027	6,586			391						227,127	30
31	Amortization of Pre-Op. & Org.		52,250										52,250	31
32	Interest		401,760	1,619			(4)						403,375	32
33	Real Estate Taxes	(1,235)											(1,235)	33
34	Rent-Facility & Grounds		(465,004)	5,038			3,635						(456,331)	34
35	Rent-Equipment & Vehicles	(7,089)			526		275						(6,288)	35
36	Other (specify):*													36
37	TOTAL Ownership	(138,201)	339,033	13,243	526		4,297						218,898	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(5,492)	(48,424)	(16,982)		(70,898)	39
40	Barber and Beauty Shops	(14,022)											(14,022)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(73,098)	73,470										372	42
43	Other (specify):*	(69,544)											(69,544)	43
44	TOTAL Special Cost Centers	(156,664)	73,470						(5,492)	(48,424)	(16,982)		(154,092)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(493,320)	412,656	136,901	776	(3,425)	125,583	(334,972)	(5,492)	(54,279)	(17,675)		(233,247)	45

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Boulevard Healthcare LLC	100%	see attached		see attached		
see attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 465,004	Brentwood Realty, LLC		$	$ (465,004)	1
2	V	32	Mortgage Interest				401,760	401,760	2
3	V	31	Amortization Expense				52,250	52,250	3
4	V	30	Depreciation Expense				350,027	350,027	4
5	V	21	Bank Charges				44	44	5
6	V	21	Office Expenses				109	109	6
7	V	42	Bed Tax (Prior Owners)				73,470	73,470	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 465,004			$ 877,660	$ * 412,656	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 617	$ 617	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	25	25	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	8,802	8,802	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	805	805	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	1,577	1,577	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	12,617	12,617	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%			21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	7,053	7,053	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	18,555	18,555	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%			24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%			25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%	3,110	3,110	26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	7,564	7,564	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	3,111	3,111	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	3,058	3,058	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	39,093	39,093	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	3,092	3,092	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	1,522	1,522	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	88	88	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	10	10	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	12,959	12,959	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	6,586	6,586	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,619	1,619	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	5,038	5,038	38
39	Total			$			$ 136,901	$ * 136,901	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 526	$ 526	15
16	V								16
17	V	17	CORPORATE ALLOCATION		QUALITY CARE MANAGEMENT	100.00%			17
18	V								18
19	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%			19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%			20
21	V								21
22	V	1	DIETICIAN SALARIES	585	QUALITY CARE MANAGEMENT	100.00%	717	132	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	118	118	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 585			$ 1,361	$ * 776	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. SAL - F. BENJAMIN	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 7,239	$ 7,239	15
16	V	17	ADMIN. SAL - STEVE VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,357	6,357	16
17	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,199	2,199	17
18	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12	12	18
19	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,335	1,335	19
20	V								20
21	V	17	CORPORATE ALLOCATION	20,567	BOULEVARD HEALTHCARE MANAGEMENT, LLC			(20,567)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,567			$ 17,142	$ * (3,425)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 233	$ 233	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	155	155	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	791	791	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,167	5,167	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,280	1,280	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,647	11,647	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	9,210	9,210	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,637	6,637	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,790	7,790	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,728	5,728	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,057	7,057	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,070	4,070	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,258	4,258	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,963	1,963	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	35,728	35,728	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,203	2,203	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	237	237	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1	1	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	17,131	17,131	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	391	391	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(4)	(4)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,635	3,635	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	275	275	38
39	Total			$			$ 125,583	$ * 125,583	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CORP ALLOC/MGMT FEE	335,076	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (335,076)	15
16	V								16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V								19
20	V	1	DIETICIAN SALARIES	390	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	404	14	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	90	90	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 335,466			$ 494	$ * (334,972)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$	AT&R II, LLC	100.00%	$	$	15
16	V	39	ANCILLARY REHAB	82,204	AT&R II, LLC	100.00%	76,712	(5,492)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,204			$ 76,712	$ * (5,492)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 42,643	Advanced Therapy and Rehab, LLC	100.00%	$ 36,788	$ (5,855)	15
16	V	39	ANCILLARY REHAB	352,689	Advanced Therapy and Rehab, LLC	100.00%	304,265	(48,424)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 395,332			$ 341,053	$ * (54,279)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 28,280	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 11,298	$ (16,982)	15
16	V	10	MEDICAL SUPPLIES	1,154	QUALITY CARE MEDICAL SUPPLY	100.00%	138	(1,016)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	323	323	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,434			$ 11,759	$ * (17,675)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB C # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Owner	Administrative	5.00%	see attached	4.79	7.37%	Sal-Quality	$ 18,555	17-7	1
2	Brian Cloch	Owner	Administrative	5.00%	see attached	4.79	7.37%	Sal-Boulevard	7,790	17-7	2
3	Jeff Elowe	Relative	Administrative	0	see attached	3.3	6.00%	Sal-Boulevard	4,040	17-7	3
4	Marilyn Cloch	Relative	Clerical	0	see attached	17.6	44.00%	Sal-Quality	1,522	21-7	4
5	Marilyn Cloch	Relative	Clerical	0	see attached	17.6	44.00%	Salary	11,374	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,281		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$	22,010	$ 617	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290		22,010	25	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396	22,010	8,802	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458	22,010	805	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527		22,010	1,577	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217	22,010	12,617	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590			7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852	22,010	7,053	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962	22,010	18,555	9
10	17	ADMIN. SAL. - B. TEITELBAUM	DIRECT/PATIENT DAYS		5	22,566	22,566			10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284			11
12	17	ADMIN. SAL. - STEVE VAN CA	DIRECT/PATIENT DAYS		3	10,508	10,508		3,110	12
13	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	258,551	8	88,849	88,849	22,010	7,564	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541		22,010	3,111	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917		22,010	3,058	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702	22,010	39,093	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		3,092	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876	22,010	1,522	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028		22,010	88	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121		22,010	10	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231		22,010	12,959	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371		22,010	6,586	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022		22,010	1,619	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175		22,010	5,038	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 136,901	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$	22,010	$ 526	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506			5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515				6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478	585	717	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973		585	118	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 1,361	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. SAL - F. BENJAMIN	PATIENT DAYS	57,507	3	$ 80,769	$ 80,769	5,154	$ 7,239	1
2	17	ADMIN. SAL - STEVE VAN CAN	PATIENT DAYS	57,507	3	70,929	70,929	5,154	6,357	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	57,507	3	24,536		5,154	2,199	3
4	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	57,507	3	131		5,154	12	4
5	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	57,507	3	14,894		5,154	1,335	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 191,259	$ 151,698		$ 17,142	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	16,856	$ 233	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		16,856	155	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	16,856	791	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	16,856	5,167	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		16,856	1,280	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	16,856	11,647	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	16,856	9,210	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	16,856	6,637	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	16,856	7,790	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	16,856		10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	16,856	5,728	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	16,856	7,057	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,121	12,121	3	4,070	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		16,856	4,258	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		16,856	1,963	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	16,856	35,728	16
17	21	SALARIES-ACCTG-B. LARIMO	DIRECT/PATIENT DAYS		7	17,000	17,000	16,856	2,203	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		16,856	237	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		16,856	1	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		16,856	17,131	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		16,856	391	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		16,856	(4)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		16,856	3,635	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		16,856	275	24
25	TOTALS					$ 1,074,661	$ 745,143		$ 125,583	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524	390	404	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564		390	90	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$ 494	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AT&R II, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION							1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						76,712	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 76,712	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						36,788	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						304,265	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 341,053	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						11,298	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						138	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						323	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 11,759	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CT # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank			Mortgage (Building Co.)			$ 11,000,000	$ 11,000,000			$ 401,760	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit	interest only	7/20/01	2,000,000	1,456,000		prime+1	17,861	6
7	A.I. Credit		X	Insurance Financing	$42,833	7/21/01	252,035	0	01/01/02	8.23%	4,963	7
8												8
9	TOTAL Facility Related				$42,833		$ 13,252,035	$ 12,456,000			$ 424,584	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Alloc from Quality Care Mgmt										1,619	11
12	Alloc from Boulevard HC Mgmt										(4)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,615	14
15	TOTALS (line 9+line14)						$ 13,252,035	$ 12,456,000			$ 426,199	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	264,188	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	164,617	2
3. Under or (over) accrual (line 2 minus line 1).	$	(99,571)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	196,836	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	97,265	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000	164,617	12

The opening tax accrual on line 1 represents the proration received at closing plus the first installment of 2000 tax.

2001 Accrual = 2000 total tax $164617 x 1.1 + Jan $17000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRENTWOOD NORTH NSG & REHAB CTR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0045484

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-35-200-002	Long Term Care Property	$ 3,238.24	$ 3,238.24
2.	15-35-200-001	Long Term Care Property	$ 159,702.76	$ 159,702.76
3.	15-35-100-003	Long Term Care Property	$ 1,676.20	$ 1,676.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 164,617.20	$ 164,617.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,758 B. General Construction Type: Exterior Brick / Masonry Frame Metal Frame Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 269,865
2. Number of Years Over Which it is Being Amortized: 5 years, 2 years
3. Current Period Amortization: 52,250
4. Dates Incurred: July 2001

Nature of Costs: Closing Costs, Financing Fees (Building Co.)
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2001	$ 2,200,000	1
2	Gazebo Property		2001	234,006	2
3	TOTALS			$ 2,434,006	3

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	248			2001	$ 8,722,400	$ 122,249	35	$ 124,606	$ 2,357	$ 124,606	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		205,225	651		839	188	839	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 8,927,625	$ 122,900		$ 125,445	$ 2,545	$ 125,445	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,927,625	$ 122,900		$ 125,445	$ 2,545	$ 125,445	1
2	WATER HEATER REPAIR	2001	612		20	31	31	31	2
3	LIGHT BALLASTS	2001	612		20	31	31	31	3
4	PLUMBING	2001	880		20	44	44	44	4
5	SIMPLEX LOCK	2001	789		20	39	39	39	5
6	SOFFIT REPAIR	2001	1,025		20	51	51	51	6
7	NETWORK CABLING	2001	20,820		20	521	521	521	7
8	NETWORK INSTALL	2001	8,215		20	206	206	206	8
9	PLUMBING	2002	889		20	44	44	44	9
10	A/C HEAT EXCHANGER	2002	685		20	34	34	34	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,962,152	$ 122,900		$ 126,446	$ 3,546	$ 126,446	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			12/14/2001	205,225	651	20	839	188	839	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 205,225	$ 651		$ 839	$ 188	$ 839	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 25,951	$ 6,586	$ 3,297	$ (3,289)	10	$ 5,623	71
72	Current Year Purchases	2,246,400	243,131	112,997	(130,134)	10	424,637	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,272,351	$ 249,717	$ 116,294	$ (133,423)		$ 430,260	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,668,509	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 372,617	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 242,740	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (129,877)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 556,706	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions Storage Rental				3,058			4
5	Allocation from Boulevard Healthcare Mgmt				3,635			5
6	Allocation from Quality Care Mgmt				5,038			6
7	TOTAL				$ 11,731 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 601 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 26,010	$		$ 26,010	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,170			5,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			520,219			520,219	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				209,252		209,252	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						64,698		64,698	13
14	TOTAL			$		$ 551,399	$ 273,950		$ 825,349	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 500	$ 791,789	1
2	Cash-Patient Deposits	2,033	2,033	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,522,413	3,522,413	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,214	102,214	6
7	Other Prepaid Expenses	2,750	2,750	7
8	Accounts Receivable (owners or related parties)	59,771	59,771	8
9	Other(specify): See supplemental schedule		187,674	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,689,681	$ 4,668,644	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,434,006	13
14	Buildings, at Historical Cost		8,722,400	14
15	Leasehold Improvements, at Historical Cost		205,225	15
16	Equipment, at Historical Cost	192,519	2,270,119	16
17	Accumulated Depreciation (book methods)	(15,613)	(365,640)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		217,615	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 176,906	$ 13,483,725	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,866,587	$ 18,152,369	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,462,493	$ 1,568,153	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,032	2,032	28
29	Short-Term Notes Payable	1,456,000	1,456,000	29
30	Accrued Salaries Payable	256,739	256,739	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,646	34,646	31
32	Accrued Real Estate Taxes(Sch.IX-B)	196,836	196,836	32
33	Accrued Interest Payable		65,518	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,160	11,160	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	572,740		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,992,646	$ 3,591,084	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,992,646	$ 14,591,084	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (126,059)	$ 3,561,285	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,866,587	$ 18,152,369	48

***(See instructions.)**

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (43,060)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (43,060)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(82,999)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (82,999)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (126,059)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,719,530	1
2	Discounts and Allowances for all Levels	(1,668,773)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,050,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,424,732	6
7	Oxygen	2,480	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,427,212	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,483	13
14	Non-Patient Meals	2,469	14
15	Telephone, Television and Radio	4,065	15
16	Rental of Facility Space		16
17	Sale of Drugs	331,556	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,084	19
20	Radiology and X-Ray	4,225	20
21	Other Medical Services	18,780	21
22	Laundry	9,528	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 408,190	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	41,987	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,928,146	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	857,637	31
32	Health Care	2,196,977	32
33	General Administration	1,363,560	33
	B. Capital Expense		
34	Ownership	611,888	34
	C. Ancillary Expense		
35	Special Cost Centers	908,915	35
36	Provider Participation Fee	72,168	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,011,145	40
41	**Income before Income Taxes (line 30 minus line 40)****	(82,999)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (82,999)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	807	823	$ 29,611	$ 35.98	1
2	Assistant Director of Nursing	841	874	26,719	30.57	2
3	Registered Nurses	21,694	23,562	549,204	23.31	3
4	Licensed Practical Nurses	6,052	6,304	131,801	20.91	4
5	Nurse Aides & Orderlies	49,210	52,154	678,162	13.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	758	774	10,104	13.05	8
9	Activity Director	1,048	1,122	19,476	17.36	9
10	Activity Assistants	4,246	4,428	50,802	11.47	10
11	Social Service Workers	1,937	2,127	34,986	16.45	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,032	43,777	21.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,812	18,227	182,197	10.00	15
16	Dishwashers					16
17	Maintenance Workers	5,421	5,661	79,818	14.10	17
18	Housekeepers	15,230	16,328	142,986	8.76	18
19	Laundry	5,858	6,325	56,449	8.92	19
20	Administrator	994	1,011	43,060	42.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,026	7,320	111,969	15.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	973	1,022	12,690	12.42	31
32	Other Health Care(specify)					32
33	Other(specify)	1,825	1,858	57,669	31.04	33
34	TOTAL (lines 1 - 33)	142,713	151,952	$ 2,261,480 *	$ 14.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	33	$ 975	01-03	35
36	Medical Director	monthly	12,000	09-03	36
37	Medical Records Consultant	40	1,704	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	9,872	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	40	2,120	12-03	45
46	Other(specify)				46
47	Alzheimer Consultant	3	460	10-03	47
48					48
49	TOTAL (lines 35 - 48)	116	$ 27,131		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,475	$ 202,787	10-03	50
51	Licensed Practical Nurses	2,629	92,249	10-03	51
52	Nurse Aides	8,859	176,775	10-03	52
53	TOTAL (lines 50 - 52)	15,963	$ 471,811		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Tracy Hoover (8/6/01-12/31/01)	Administrator	0	43,060
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,060

B. Administrative - Other

Description	Amount
Boulevard Healthcare Management	$ 355,643
TOTAL (agree to Schedule V, line 17, col. 3)	$ 355,643
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	$ 897
Hansen Associates	Architect	1,835
Personnel Planners	Unemployment Consult	360
MES / HPSI	Purchasing Consultant	175
Health Data Systems	Computer Services	3,172
RMS Business Systems	Computer Services	2,073
Accu-Med Services	Computer Services	1,180
Extended Care Info Network	Computer Services	775
RedLine Medical Supply	Computer Services	64
Network Solutions	Computer Services	70
CDW Computer Solutions	Computer Services	805
Frost Ruttenberg & Rothblatt	Accounting	83
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,489

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,844
Unemployment Compensation Insurance	33,055
FICA Taxes	173,003
Employee Health Insurance	62,602
Employee Meals	2,410
Illinois Municipal Retirement Fund (IMRF)*	
401 K Expense	8,916
Other Employee Benefits	6,459
Holiday Expense	2,089
Life Insurance	982
Disability Insurance	1,318
TOTAL (agree to Schedule V, line 22, col.8)	$ 329,678

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	39,190
Health Care Worker Background Check	336
(Indicate # of checks performed 28)	
Advertising	93,772
Dues & Subscriptions	858
Licneses & Fees	2,009
Allocation from Quality Care Mgmt	3,058
Allocation from Boulevard HC Mgmt	1,975
Less: Public Relations Expense	
Non-allowable advertising	(93,772)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,426

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,350
Allocation from Quality Care Mgmt	88
Allocation from Boulevard HC Mgmt	237
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,675

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRENTWOOD NORTH NSG & REHAB CTR # 0045484 Report Period Beginning: 07/21/01 Ending: 01/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,038** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **72,540**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,410** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,109**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees